
The American Legion Magazine

May, 2003

Volume 154, Issue 5

A Storm On The Horizon

Interview with National Commander Ronald F. Conley

Air Force veteran Ronald F. Conley, a third-generation pipefitter from Pittsburgh, has been on a strange journey this year.

All across America, he has eschewed cocktail hours and banquet tables to instead punch the clock each morning, roll up his sleeves and get to work – as he has done throughout his career – in an attempt to steer VA's beleaguered health-care system away from disaster.

It has not been an easy job – often frustrating, often fraught with political chutes and ladders. But when he was sworn in as national commander of The American Legion in August 2002, Conley was not expecting a vacation.

While polo-shirted snowbirds hit golf balls around Tampa, Fla., Conley was at Bay Pines VA Medical Center, listening to inside stories from disgruntled patients and overworked nurses. While one-armed bandits inhaled and exhaled cash down on the strip, Conley was at an ambulatory care center leased by VA in Las Vegas, asking why the building was collapsing five years after it was built. While ordinary winter travelers to Idaho were renting SUVs and heading for the Valley, Conley was trying to work the math of how a Boise VA hospital might function – with its 5,000-deep waiting list – if all the National Guardsmen and Reserves on staff were suddenly called to active duty. In Dallas, the commander gazed down the dark corridor of a long-term care facility and wondered if he was looking at a ghost from the 1940s. While others vacationed, Conley was on an extraordinary fact-finding odyssey.

It was a challenge he made to himself shortly after assuming leadership of the world's largest veterans' service organization. Conley – a veterans' health-care advocate for more than three decades in Pennsylvania – set out to visit at least one VA health-care facility in every state he would visit this year. Firsthand and coast-to-coast, he wanted to understand the breadth and depth of America's VA health-care problem. Soon into the journey, he realized the situation had long ago passed the "problem" stage.

"We have a veterans' health-care crisis throughout this country right now," Conley said during a recent stop at the Legion's National Headquarters in Indianapolis. By then, he had visited about 20 VA medical facilities in as many states. "We are creating more veterans every day, a great many of whom need, or are going to need, health care. We've got to make sure the VA system is in place and working efficiently, with timely, quality care. We've got to take care of these veterans."

As VA considers urgent new ways to cut costs – from downsizing medical facilities to denying enrollment for certain demographic classes of veterans – Conley hears the low thunder of change. It is a storm that has been years in the gathering. It has been gathering in overbooked VA medical centers where budgets seem built to fail, in regional service networks called "VISNs" (Veterans Integrated Service Networks) that compete like sharks in a pool of fixed federal funds, and in board rooms where business models and budget tools just can't seem to find a way to dig a secure bunker for America's moral obligation to veterans.

Something is about to break. Conley knows it. VA knows it. Congress knows it. Hundreds of thousands of veterans who are waiting in line for health care know it.

In a recent interview with editors of The American Legion Magazine, the national commander described the status of veterans' health care in this nation, how and why it reached this boiling point, and what can be done before it's too late.

The American Legion Magazine: Why should Americans pay for veterans' health care?

Ronald F. Conley: Let's go back to the rationale for any country to provide benefits and health care to veterans. It comes from the Judeo-Christian tradition, since the time of the Greek city-state, through Rome, through Western civilization, through all elements of civilization where we inherited our values. Civilized nations provide benefits for men and women who serve to protect their way of life.

In the 20th and 21st centuries, the American people – through their elected officials – have provided these benefits through the Department of Veterans Affairs and the Veterans Health Administration. Any young man or woman who raises his or her right hand and takes the soldier's oath – the oath to defend their country, no matter the place or branch of service – the government has an unwritten contract to care for them. It is a moral obligation. These men and women performed the ultimate act of citizenship. They volunteered or were drafted and put on our nation's uniform to defend with their lives, if necessary, our way of life.

Many do not return with injuries you can see right away. But you can be assured they come back permanently changed. Military service is a life-changing experience. We have learned over the years that many of these changes make themselves known later in life: hypertension and PTSD, to name two. There may come a time, depending on personal circumstances, when a veteran needs to turn to VA for care. That is what VA was designed to do, provide that care.

Everyone who serves gives up time. That's time away from their families, away from jobs, away from securing an education. They put their lives on hold and took the risk of putting their lives on the line. That is the basis for VA health care, the reason we provide it. The least this government can do is take care of the health needs of those who were willing to be placed in harm's way for America.

TALM: What was it like when you first joined The American Legion?

RFC: VA had a hospital-based, managed-care system that focused on the service-connected, the elderly, the tired, the poor – and, if not by policy certainly in practice, a full continuum of health care was provided. You had eligibility standards, but VA would not just care for service-connected problems. If you were a veteran and needed help, you were not turned down. And there was not the waiting in line we have now.

TALM: So, if you were shot in the foot during your tour of duty and you went into a VA facility later with a broken arm, how would they treat you?

RFC: That's what happened, and practice makes policy. Imagine a veteran coming into a VA hospital with a leg cut below the knee – 40-percent service-connected – who needs his heart looked at. No way was the VA doctor going to tell him to go somewhere else. In reality, it was an all-inclusive system.

TALM: What changed?

RFC: VA health care gradually shifted as various legislative changes came into effect. Delivery of care changed from the inpatient model to more outpatient and home-based services. In the 1980s, they started categorizing veterans. You were an A veteran, a B veteran, a C veteran. Means testing was extended to all veterans, and copayments and third-party reimbursements from insurance companies came in. Now it's priority groups 1, 2, 3, 4, etc., as new and different criteria were established to determine where you fit and how you were categorized.

Some veterans got squeezed out. In Pennsylvania, wives started calling me, wives of veterans who were in VA facilities saying their husbands were being forced out of the system. It used to be VA had some discretion because the system was not nearly so budget-driven as it is now. Families were told to move their husbands and fathers into nursing homes or VA would do it for them. Some VAs would pick up the cost for 30 days, 60 days or 90 days, but then on, the burden was on the families. We made a push under (former VA Secretary) Jesse Brown and (former VA Undersecretary Kenneth) Kizer to put a moratorium on releasing long-term-care veterans from these hospitals. We were able to get that moratorium passed. Some of those veterans are deceased now, but they ended up staying in their facility, the facility they were used to, and they ended up dying with some dignity.

A veteran is a veteran, no matter what category he or she is put in, no matter what the means tests conclude. In the late 1990s, VA expanded enrollment, and care was made available to all who served. It was a good deal in many ways, and VA actively reached out to veterans who did not know they now were eligible for health-care benefits. VA aggressively marketed to get them to enroll. And they did.

TALM: What was the problem with that?

RFC: They expanded the system and took in more veterans, but they didn't substantially change the budget. The philosophy of a VA for all veterans was great, but paying for it was a different story. That's how we got into the rationing of health care. That's what you do when you don't have enough to go around. You ration.

TALM: Didn't VA's ability to collect third-party payments offset the cost of handling the greater patient load?

RFC: The Veterans Health Care Eligibility Reform Act of 1996 told veterans they could all come. "Come on, enroll the system," we were told. And yes, VA was able to start collecting and retaining first- and third-party reimbursements. But you have to understand that they cannot collect Medicare. That's a big difference between VA and other hospitals. And even though VA could bill third parties, they had to jump through several hoops. They had to learn how to bill insurance companies. A lot of health-insurance policies back then said if you received care through a federal institution, you were exempt from coverage. That meant they had to change the law. Even then, some companies did not pay dollar for dollar. It took education, and it took time.

Once VA learned the billing process, they got pretty darned good at collecting first and third-party reimbursements. Now, every time a VA hospital director beats his target for those collections, the target is raised. That director does benefit from having beaten the target. The reward for a surplus at the end of the year is a higher collection target the next time around. We have found this everywhere we have gone this year. In one state, the target was \$10 million; they collected \$13 million in third-party reimbursements, and so the target was raised to \$15 million. And if the directors don't collect that money, they have to find it somewhere else, or they have to cut, if they want to meet the budget.

TALM: When targets cannot be hit, what are the options?

RFC: Medicine, by its very nature, is labor-intensive – doctors, pharmacists, nurses, medical staff, administrators. There are several things you do if you need to cut costs in a medical facility. You put off purchases, facility maintenance and minor construction. You cut back on employees. That's the quickest way. In places where the budget isn't sufficient to meet demand, cutting costs means cutting people. VA has empty beds and empty wards because they have been systematically downsizing VA – both the people and facilities – because of a lack of dollars.

Facilities inside VA compete to see who can cut costs more. One VISN director had a million-dollar slush fund he was paying to employees who came up with ideas about how to cut costs. It became very aggressive among employees trying to access that money. You can't do that. You cannot push people out of the system to save money ... just get rid of them to get rid of the cost. I told them that.

TALM: Is the CARES (Capital Asset Realignment for Enhanced Services) program a viable opportunity to create a more efficient system?

RFC: The potential is there, as long as the final product does what it is supposed to do – and that's improve quality care and access for veterans. It cannot be budget-driven. Throughout the process, as VA has tried to determine what facilities should be realigned – consolidated, expanded or condemned altogether – we have fought to keep stakeholder voices very audible. Sometimes things like this happen in a vacuum. We were concerned when the national CARES commission, the body that will make final recommendations to the secretary this fall, was initially being assembled without ample veteran representation. I applaud the VA secretary for placing a member of The American Legion on that committee. Veteran participation is important if there is to be veteran buy-in. They need not only be informed – but also involved – in the decision-making process, at all levels.

I cannot say realignment is bad in and of itself. If it makes a more efficient system better able to serve veterans, of course I am all for it. If the final plan aims only to cut costs and make a smaller VA system, I think the plan will be rejected by veterans and their organizations.

TALM: How does the VA medical-school affiliation program help control costs?

RFC: Every VA I went to that has any kind of agreement with a medical school tells me that if they did not have the agreement, they would not be able to staff their hospitals properly. Doctors do not come to VA hospitals because of money. They come for an education. They come because they are able to do research they are unable to do elsewhere. Because of that, VA hospitals are able to attract top-notch doctors.

Right here in Indianapolis, the VA hospital does 200 heart operations a year. Two hundred. I think that's a pretty high number, and I think that shows one of the most important purposes of that hospital, and of VA hospitals in general. research gave us the pacemaker. Prosthetic limbs. Breakthroughs in the treatment of spinal cord injuries. There are dozens of examples. This relationship works because VA hospitals provide real patients, willing patients, and an environment for medical innovation that does not exist anywhere else. The affiliation program works because it is good for the medical researcher, and it is good for the veteran. Also, more than 60,000 medical students a year receive training through this affiliation. It is a national asset.

TALM: Why can't VA health care be provided at non-VA hospitals and clinics?

RFC: A voucher system? It's not going to work. VA health care is specialized health care. We have found that out when Vietnam War veterans came home that most private hospitals didn't understand Agent Orange or PTSD. They were not programmed to provide the kind of specialized care necessary to serve people with spinal cord injuries or who needed prosthetic limbs. We need a health system that's in tune to understand the unique needs of veterans. War illness, PTSD, Agent Orange, spinal-cord injuries – public and private hospitals are not going to be able to help them. Also, VA has an important role as the main backup to the military medical care system in case of federal emergency. I don't see how you can voucher that out.

TALM: Is any region of the country handling the challenges better than any other?

RFC: They're all under-funded, so they all have similar challenges. So, really, the answer is no.

TALM: Across the country, what are the consistencies?

RFC: The general operational issues through VA are the same: the backlog of veterans trying to get access to primary care, problems recruiting and keeping doctors, nurses and pharmacists, and a budget that does not reflect demand. We also have a great concern about a lack of care for Alzheimer's disease, dementia and psychiatric patients. There is a substantial number of veterans who have psychiatric problems. Not all VAs are equipped to handle that, or they handle it in a small way.

TALM: What do you mean by the "backlog," and how many veterans are in it?

RFC: "VA backlog" refers to people who are waiting for VA to serve them. Decisions on initial claims, cases hung up in the appeals process, overbooked facilities and appointments that are rescheduled over and over because so many others are ahead in line – that's all backlog. Some veterans have been told their VA facilities are so backed up, they are no longer accepting new patients. And there are some who don't believe they will ever see a VA doctor, and so they give up. Maybe they go elsewhere. Maybe they don't have an elsewhere to go. The backlog takes many forms and should not exist at all.

How many are in it? I have seen a dozen different figures. They're all in the hundreds of thousands. The VA secretary says they are making progress toward correcting the problem, but I believe that when we're talking about progress

from 300,000 to 200,000, there's still far too many people waiting to get through the system. One is too many.

How many people outside VA would tolerate a doctor's appointment that can't be made inside of a year? It happens over the country, all the time. Progress is not enough. When the VA Undersecretary for Health tells the House Veterans Affairs Committee that demand for VA services is unsustainable, I question how much progress we are making. These veterans are not in line for Disneyland. They need to see doctors.

In the "I Am Not a Number" campaign this year, The American Legion received thousands of personal testimonies from veterans who have been waiting too long for health care. Their testimonies confirmed what we have been saying all along – that the overall quality of VA health care is great. The health-care professionals providing that care are outstanding. But getting in to see them is very difficult. Many of the respondents could not comment on VA's quality care because they had not yet seen a doctor after months of waiting. Many of them wrote in to say they gave up trying to get an appointment. When they were told it would be a year before they could see a doctor, they thought it was some kind of joke. That is not a viable health-care system. Nor is it a tolerable one.

TALM: What do you think of the VISN system?

RFC: We used to have one VA. Now we have 21 VAs. We need to go back to having just one, uniform VA health-care system.

The problem is that each VISN is in competition with the other, for dollars in a central pool in Washington. They set the VISNs. Then they set up VERA (Veterans Equitable Resource Allocation) to fund them. Inevitably, politics enter into it – and it all became about who was going to get how much of the pie. VISNs went into competition with each other, and then facilities inside each VISN were in competition among themselves.

TALM: Isn't competition generally good for quality?

RFC: Competition is destroying VA. The political process comes into play. The veterans' health-care needs in Pennsylvania or Wyoming or Texas or Maine or Florida or Idaho are really the same. And yet there is this competition for the dollar, the idea that I can treat my veteran better than you can treat your veteran. I don't think that's healthy competition. That's politics. Competition is good for making money. That's not VA's mission. VA should be held responsible for maintaining quality care. But when there is a fixed amount of money, they are forced to compete for lack of funding.

TALM: What would happen if the VISN system were collapsed?

RFC: If we collapse the VISNs, I think we would have a better, more cohesive system. Then comes the question, what are we going to do with all the people who were running these VISNs? I have an idea. Let's put them back to work for veterans. They are good people.

TALM: What can be done about the VA health-care budget shortfalls?

RFC: Mandatory funding. We need VA to receive the funding required to fulfill its mission – quality care in a timely manner for veterans of the armed forces. VA is staffed, directed and monitored by people who all share the same goals. But I have talked to some employees and nurses who are so overworked and so dedicated to their missions that when they go home, they literally break down and cry. They are overwhelmed.

The goal of quality care in a timely manner cannot be achieved with a discretionary budget. That's the problem. Veterans should not have to fall in line with all the special-interest groups out there who come begging Congress to fund their pet projects. Veterans should not have to sell Congress over and over on why the government should live up to its obligations. Veterans should not have to sacrifice their health care to fund foreign-aid packages and pork-bar projects. It's a matter of setting correct priorities.

We solve it all with mandatory-funding legislation, introduced last fall in the 107th Congress and already this year, the Senate of the 108th. Mandatory funding would give VA the resources it needs to meet its costs, a dollars-per-veteran budget, indexed annually for inflation. VA also needs the ability to bill Medicare, to be fair. The bottom line VA needs a budget it can depend on. Otherwise, the response to overwhelming demand will always be to cut costs and services, and to exclude certain veterans.

TALM: Wouldn't mandatory funding for veterans health care put too great a strain on the federal budget, especially a time of war?

RFC: Veterans' health care is a delayed cost of war. We are already making budget plans to rebuild Baghdad after war. We should also be making budget plans, by guaranteeing funding for veterans' health care, for after the war. It is not a budget buster. In fact, I think it can save federal dollars in the long run.

Also, I do not believe that if we have mandatory funding every veteran in America is going to use VA. But if we have it we won't have to play the political shell game anymore.

The American Legion is not being fiscally irresponsible about this. We know there is no big money well in Washington D.C., and we can't reach in and pull out dollars and dollars and dollars. We realize there is a budget crunch. We look at it intelligently, and we make our recommendations on that intelligent view. We're not asking for the moon and the stars and the sun. We are just asking for a reasonable amount of money that we feel can address the health care of the veterans of this nation. Veterans need to be a higher priority.

TALM: Do veterans feel they are being abandoned by the government they swore to protect?

RFC: They are becoming disillusioned. Veterans are now being driven away from the system, but at the same time the system relies on their numbers for budget dollars. It doesn't make any sense to me. It's a dog chasing his tail.

TALM: Why are veterans still flocking into the system?

RFC: One reason is quality of care. People are always going to go where they can get the best treatment. But you talk about quality of care all you want; if you cannot get in to receive that care, what's the value? Not much. Care delayed is care denied. People also are accessing the system more and more because they are losing their hospital insurance elsewhere. Others are accessing because they have lost jobs.

TALM: Does the public understand the magnitude of this problem?

RFC: People who are not familiar with the system think VA health care is free for veterans. It's not free. Veterans earned this care. The veteran is paying for it. It's a budget game. Another thing the public does not understand is that the number of veterans is not, as so many say, declining as much as they claim it is. That's another public misconception. The number of veterans is very likely to increase as the war on terrorism progresses.

You go into the service believing that the government will be there for you when you get out. Then you go down to VA health-care facility and find out you can't get in because it just wasn't in the budget this time. You get to the point of frustration. You feel betrayed. That is something the public generally does not understand.

As I travel and do interviews on this, the reporters doing the interviews are appalled. They do not realize that care for veterans is like this in America. They do not realize the impact of budget shortfalls or that this crisis is going to get worse until we improve it. It's not well known by the nonveteran population. And if people don't know there's a problem, they will keep taking away and taking away from you. We're trying to turn that around. We have an educational challenge in front of us.

TALM: Is there more at stake here than the financial viability of the VA health-care system?

RFC: Health care is a symptom of a bigger problem. Our nation has a tendency to forget those who fought after the war is over. The real insult is that veterans now have to fight to even have a voice on decisions that affect them directly. I don't think my solutions are necessarily 100-percent correct or best. I don't believe VA's solutions are necessarily 100-percent correct or best. But what a wonderful world it would be if we could sit down and hit 90 percent together. As intelligent human beings, everybody needs to sit down at the same table and discuss the problem. I would go anywhere the secretary of Veterans Affairs wants to go, to meet with him. I would meet with the president, and would meet with members of Congress to discuss these problems.

The person who went into the military wanted an opportunity for the American dream. A family. School. A job. Retirement. That's all. That is the average feeling of the veteran. The veteran, however, has not been able to achieve that dream. The moral obligation has been broken. That is why veterans are disillusioned, and that is why veterans health care is so important. Veterans need timely health care, yes. Is it in a state of crisis? Yes. We are also at a critical point in the way America thinks about veterans. What we do now to solve the VA health-care crisis will have great bearing on veteran treatment in years to come.

No one is going to make our case for us. It is up to us to see to it that the government holds up its end of the bargain with veterans. We have to stay aware of the problem nationally and keep pressure on our officials locally. We need to fight for mandatory funding. It's not going to take just one phone call. It's not going to take writing one letter. It's going to take time and persistence and constantly reminding those we put in office that they have a moral obligation to uphold.

Jeff Stoffer is managing editor of *The American Legion Magazine*.

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